Discourse Analysis of Navy Leaders' Attitudes about Mental Health Problems

Richard J. Westphal
Captain, Nurse Corps, United States Navy

University of Virginia
Department of Nursing
Charlottesville, Virginia

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Abstract

Mental disorders are a significant source of medical and occupational morbidity for sailors. The literature suggests that stigma, fear of negative career impact, and subordinates concern about leaders' attitudes are significant barriers to the use of mental health services. Semi-structured interviews and military policies were used as data sources to analyze the language, knowledge, and attitudes of Navy surface fleet leaders about mental illness and mental health treatment using Foucault's concept of discourse analysis. A discourse is a system of knowledge that influences language, perceptions, values, and social practices. The data showed that concerns about sailors' mental combat readiness, not mental illness stigma, were the dominant discourse of leaders' attitudes about mental illness and subordinates' mental health services use. In particular, organizational differences between the surface warfare and the mental health communities may influence leaders' attitudes more than stigma. This study provides an elaborated view of mental health knowledge and power within a Navy community. That view can be used to identify practical and concrete implications for further research on stigma in the military and for improvements to fleet mental health services.

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Summary

Mental disorders are a significant source of medical morbidity and lost productivity for active duty military members. The majority of military personnel believe that using mental health services will cause career harm. Further, over 81% of those with mental health problems do not seek treatment. Stigma and fear of negative career impact represent a significant barrier to mental health services use. Military members have identified that concerns about leaders' attitudes is one type of barrier to seeking help. Military leaders are in positions of authority over subordinates careers and access to mental health services. Military policies and leaders' perceptions of mental illness are potential sources of organizational norms regarding mental health service use.

This study used semi-structured interviews and military policies as data sources to analyze the language, knowledge, and attitudes of Navy surface fleet leaders about mental illness and mental health treatment using Foucault's concept of discourse analysis. A discourse is a system of knowledge that influences language, perceptions, values, and social practices.

Mental illness stigma was not a dominant influence of leaders' attitude about mental illness and subordinates use of mental health services. Instead of stigma, leaders expressed frustration with accessing and using mental health resources to ensure that sailors are mentally combat ready. The source of the leaders' frustration is the fundamental difference between the Navy surface warfare and mental health communities. Differences between the two communities are aggravated by inconsistent policies, separate organizational expectations, unique knowledge structures, and specialized language.

This study provided an initial look at the attitudes that Navy surface warfare leaders' have regarding mental illness and the use of mental health services. The findings indicate that differences in organizational structures may have a stronger influence on leaders' attitudes than stigma. Knowledge about organizational barriers can be used to design improvements to fleet mental health services.

Introduction

Mental disorders are the most significant source of medical and occupational morbidity among active duty military members (Hoge et al., 2002). Since 1995, hospital admissions for mental disorders are the second leading cause of hospitalization of members of the active duty military population. The leading mental disorders are alcohol-related disorders, adjustment disorders, major depression, and personality disorders. Hourani and Yuan (1999) used instruments and methods similar to those of the Epidemiologic Catchment Area (ECA) survey and identified a 40% lifetime and 21% current prevalence of mental disorders in a Navy and Marine Corps population, with more than 81% of those with active disorders not seeking any mental health services.

Occupational stress contributes to mental health problems in the U. S. military. Military service places demands on its members and their families that are different from the demands of most other occupations. In a study by Bray et al. (2000), 23.8% of military members self-reported high levels of life stress. The top five sources of stress identified in the Bray et al. (2000) study were family separation, financial problems,

workloads, job-versus-family conflicts, and family changes. High-stress service members had greater risks for low productivity, increased workplace accidents, and maladaptive coping. In the general military population, nearly 25% used alcohol and 4% considered suicide as coping options (Bray et al., 2000).

Even though mental disorders account for a significant amount of health care use and occupational risk, many active duty military and their family members are not seeking help. The 1995 Department of Defense (DoD) health beneficiary survey showed that fewer than 19% of respondents with major depression sought treatment (Constantian, 1998). In the general U. S. population, over 30% of National Comorbidity Study (NCS) respondents with major depression sought treatment within the first year of symptom onset (Kessler, Olfson, & Berglund, 1998). The self-reported need for any type of mental health services was 18% in both the civilian and military workforce (Bray et al., 2000; Kessler & Frank, 1997). About half of the civilian respondents sought formal treatment and less than a quarter of the military respondents used formal mental health services.

Significant costs are associated with untreated mental health problems in the military workplace. Some direct costs relate to the replacement of service members who leave or are compelled to leave before completing their contract; others are increased medical care costs associated with delayed treatment and expenditures for military resources to transport patients from remote duty assignments to treatment facilities. Stigma as a barrier to treatment is costly because delays in treatment are associated with increased symptom burden, family disruption, organizational demands, and expenditure of fixed fiscal resources. As in the civilian literature, there are very few studies of the military population that describe the occupational effects of stigma. Studies do emphasize, however, that most service members perceive that participating in outpatient or inpatient mental health services will harm their military career (Bray et al., 2000; Britt, 2000). At least parts of service members' perceptions are accurate. Hoge et al. (2002) discovered that inpatient treatment did have a negative career impact. Attrition from the military following hospitalization for a mental disorder between 1996 and 1998 was 61% within 12 months and 74% within 24 months. The Hoge et al. (2002) investigation did not shed light on the factors that contributed to such high attrition from military service. Unknown are the actual experience of service members upon discharge from the hospital, the level of support or social distance experienced upon returning to work, and the related attitudes and career decisions made by military leaders.

Some of the knowledge gained about stigma in the corporate workplace can provide insights into stigma in the military setting. It is important to recognize, however, that the settings and workers have some significant differences. Compared with large corporations, the military workforce has unique entry and retention requirements that are intended to exclude those with mental disorders. Military group norms and regulations with low tolerance for deviance reinforce behavioral expectations with punitive sanctions. In civilian corporations, employees can reasonably expect to retain the privacy of their medical records and treatment history. In the military setting, in contrast, the commanding officer has the right, and many would argue an obligation, to be knowledgeable about any condition that would affect service members' ability to perform their duties.

The underuse of mental health services by American military personnel is widespread and contributes to personal suffering, increased family burden, decreased organizational efficiency, increased training expenditures, and increased health care costs (Bray et al., 2000; Britt, 2000; Constantian, 1998; Hoge et al., 2002; Hourani & Yuan, 1999). Stigma and fear of negative career impact represent a significant barrier to seeking help for mental health problems. Delays in seeking mental health services increase the risks of developing mental illness, exacerbating physiological symptoms, and negative career impact. Negative attitudes about mental health problems among leaders and managers are a potential source of negative career impact. This problem, however, is barely acknowledged in the research and professional literature concerning mental health in the military.

Stigma in the Military

The symptoms of mental disorders impair work and social functions that result in burdens on the individual, family, and Navy organization. In spite of the significant health impact of mental disorders in the U. S. military, mental health-related programs have not had the same organizational support as those devoted to smoking cessation, physical fitness, motor vehicle safety, and alcohol awareness. Mental illness stigma research with a military population, as a military personnel research priority, is sparse compared with stigma research outside the military. A search of published research and unpublished military medical research reports yielded seven studies relevant to stigma. Two studies specifically studied stigma (Britt, 2000; Porter & Johnson, 1994). One study included a survey question on stigma (Bray et al., 2000). The remaining four studies had findings or discussions that reflected stigma effects as a potentially influencing variable (Hourani & Yuan, 1999; Knowlan, Arguello, & Stewart, 2001; McNulty, 1997; Rowan, 1996).

Porter and Johnson (1994) surveyed the attitudes of Navy and Marine Corps commanding and executive officers toward service members who had received mental health services. The authors concluded that the respondents were neutral in their attitude about the reliability and competence of those who had used mental health services. Unfortunately, this study has limitations that undermine the authors' conclusions. Theoretically, the authors chose "sometimes" to mean neutral. The phrasing of some of the forced choice responses precluded a neutral answer. For example, "Is having had prior mental health care a factor in consideration for promotion?" (p. 604). The scale option of "sometimes" to this statement reflects an agreement with the statement rather than a neutral position. Additionally, 33% of the respondents included comments in the survey. Of the qualitative statements, 20% were negative toward the survey, and 10% were negative toward health care recipients, indicating that there may be issues not addressed by the survey questions. This study did not address what attributes military leaders assign to recipients of mental health services and whether those attributes are used in decision making.

Britt (2000) studied the perception of stigma in Army soldiers returning from a peacekeeping mission. Returning soldiers were required to participate in physiological and psychological screening as part of their transition back to the United States. The findings showed several factors supporting the role of stigma associated with military

mental health services. Service members believed that admitting a psychological problem would be more stigmatizing than admitting a medical problem. More than half believed that admitting a psychological problem would harm a military career. Those who screened positive for psychological referral experienced more concern about stigma than those who screened negative. Service members reported a lesser likelihood of completing a psychological referral than a medical referral.

The belief about career harm is an important clue to understanding stigma in the military. Authority over a service member's career resides with the commanding officer of that service member. Peers and immediate supervisors may be able to influence leaders, but they do not have career-level decision-making power. The Britt (2000) study implies a belief that admitting a psychological problem would result in adverse action by service members' leaders.

The 1998 DoD survey of health-related behaviors among military personnel (Bray et al., 2000) identified underuse of mental health services. This study included a question about the potential for mental health counseling to damage a military career. Psychological counseling was an identified need by 18% of the sample. Of those who identified a counseling need, 5% received mental health care and 4% participated in pastoral care. Regarding the perception of a negative career impact from mental health services, 20% believed that participating in mental health services would be career damaging, 60% were uncertain, and 20% believed that it would not be career damaging. It is unlikely that individuals would take a career-risking action if they were uncertain of the outcome of that action. Without a respondent demographic description, it is not possible to determine any common characteristics among the 20% of service members who were not concerned about negative career impact.

In a review of Air Force mental health outpatient referral patterns, Rowan (1996) found that self-referral rates were lowest for military students, lower-ranking enlisted, and personnel requiring a special duty status related to weapons or security clearances. Those service members who did self-refer for mental health services had less severe symptoms and were more senior in rank than those with involuntary referrals. Consistent with the differences in symptom severity, there were differences in career impact between self-referrals and involuntary referrals in terms of mandatory treatment (2% versus 94%), recommendation for career change (7% versus 69%), and recommendation for military discharge (5% versus 86%). For some people, increased symptom severity impairs personal functioning so much that they either seek help or are coerced into obtaining services (Lidz et al., 1998).

Hourani and Yuan (1999) found that over 81% of active duty Navy and Marine Corps personnel identified with active disorders by survey-based clinical screening measures did not seek any mental health services. Highlighting the significant underuse of mental health services, the authors stressed the importance of "removing the stigma or perceived punishment associated with mental illness within the ranks and . . . address[ing] treatment and prevention issues without adverse consequences to a sailor's or Marine's military career" (p. 180). The idea of perceived punishment presented by Hourani and Yuan is consistent with leaders' role in making decisions about subordinates' careers. Organizationally, punishment decisions are restricted to the commanding officer.

McNulty (1997) discussed the fear of identification as a possible contributor to a low response rate to a survey of Navy nurses in an eating disorder study. McNulty described those military nurses with eating disorder diagnoses as having a low probability of remaining on active duty. She states, "Anorexia and bulimia will remain closet illnesses until changes within the military system occur" (McNulty, 1997, p. 706). Even though McNulty does not discuss specific recommendations for system-wide changes, it is clear that she perceives a career risk to military women who disclose an eating disorder problem.

In 2001, Knowlan et al. (2001) reported that the Navy has the capability to treat and retain sailors with a diagnosis of depression. The recommendation to provide treatment while keeping sailors on active duty was based on the efficacy and the mild side-effect profile of selective serotonin reuptake inhibitors (SSRIs). In addition to the efficacy of the medication, medical department personnel reported a favorable attitude toward prescribing SSRIs to active duty members. This author's review of the responses by specialty showed that those physicians who are attached to combat commands had the lowest use of SSRIs and the lowest acceptance of active duty members who needed SSRIs. The result of this study indicates a possible difference between combat unit and hospital-based providers in their beliefs about mental health patients. Given the importance of military leaders' influence in combat units, the low acceptance and support of SSRI use among combat unit physicians may reflect the unit mission and culture more than their individual beliefs.

There is no conclusive evidence to describe the extent of stigma in the active duty population or among commanding officers. There is enough evidence, however, to suggest that a belief about negative career impact from receiving mental health treatment is one of the factors contributing to the underuse of mental health services by military personnel. Proposed sources of stigma and barriers to use of Navy mental health services include (1) individual beliefs about mental illness and anticipation of stigmatizing responses; (2) command leadership beliefs about the role of mental health services, the competence of former patients, and leadership responsibility to the needs of the Navy (command cohesion and integrity); (3) coworker and first-line supervisor beliefs about and behaviors toward mental health issues; (4) naval personnel and health care policies that use mental health services as a mechanism for administratively discharging "undesirables"; and (5) loss of privacy resulting from a commanding officer's need to know about their subordinates' health status. One potential stigma source that is directly related to the fear of adverse career impact consists of the beliefs of military leaders about mental illness and the role that military mental health services plays in maintaining military readiness.

Coinciding with resistance to use of mental health services is an increasing body of knowledge indicating that early mental health intervention for stressful and traumatic events reduces the incidence and severity of psychopathology. Increasingly, mental health teams are deployed with combat units. The effectiveness of operational mental health promotion will depend, in great measure, on the beliefs of military leaders about mental health services and of the service members who participate in those services. It is important that military mental health providers and health policy leaders understand the

perceptions of military leaders toward mental health services and toward their subordinates who use those services.

Purpose

The purpose of this study was to analyze the language, knowledge, and values of Navy leaders about mental illness and mental health treatment in the context of Navy policies and surface warfare community. With the lack of stigma research in the military culture, knowledge that mental illness stigma exists comes in part from the military's oral history that establishes cultural norms and expectations. The expectations of leaders, particularly in regard to mental health issues, can produce dramatic differences in the use of mental health services and the outcomes of interventions. This study begins to address this significant gap in the research literature by describing the perceptions of Navy leaders about psychiatric symptoms and the use of mental health services.

Threats to internal and external validity have less salience for a qualitative study but still present as potential limitations. Internal validity in a qualitative study depends upon the fit of the explanation to the description (Janesick, 2000). Attempts to support the internal validity of this study were the use of a member check and a peer debriefer. An external validity limitation is based on the nature of qualitative research as a method of inquiry. Although this study provides promising data about military leaders' attitudes regarding mental health problems and subordinates who use mental health services, the results are not generalizable. The findings of this discourse analysis are constrained to the participants and the interpretations of the investigator. Specifically, the discursive practices and power relations identified through participant interviews are limited to the participants and cannot be generalized to Navy leaders in a type of command, a region, an officer community, or the Navy in general. Another limitation of this study was the absence of interview data from sailors who used mental health services and mental health providers.

Even with the limitation of generalizability, this study adds to the body of knowledge regarding mental health beliefs in the military. More important, this study will form a conceptual foundation for the systematic development of larger population-based studies that will be able to examine the mental illness beliefs of military leaders and subordinates. Because the military lifestyle includes an occupation with high-risk and high-stress potential, it is important to expand our knowledge about the risks and potential benefits of seeking mental health services with systematic and ongoing scientific inquiries.

Methods, Assumptions and Procedures

Discourse Analysis

Negative attitudes about mental health problems that stigmatize members of the military are a social problem that affects individuals, family systems, and the Navy organization. In this context, stigma is an ideology linked to the social practices in these institutions. The language, perceptions, values, and social practices that communicate an ideology form a discourse. Discourses provide verbal or written texts that are analyzable material for social research. The Powers (2001) method of discourse analysis was used as an analytical frameworkfor this study.

Powers (2001) used Foucault's poststructural philosophy of discourses as the theoretical lens for conducting a discourse analysis (Dreyfus & Rabinow, 1982; Foucault, 1972; Foucault & Gordon, 1980; Foucault, Rabinow, & Rose, 2003). Foucault described discourses as groupings of signs or symbols (statements) that suggest a consistent pattern in how they function as constituents of a system of knowledge. The patterns of statements form the discursive practices, the actions and objects, in a discourse. The system of knowledge is a form of power that acts as a sphere of influence over language, perceptions, values, and social practices of participants in the discourse. Discourses function to fulfill a social purpose and to maintain social order by authoritatively describing normative expectations propagated by specific institutions.

A caveat is in order for reading a discourse analysis. Foucault used common words (such as *genealogy*, *archeology*, *power*) in uncommon ways to expand the boundaries of investigation and thought (Foucault et al., 2003). Appendix A is a glossary of key discourse analysis terms used in this study. A Foucaultian discourse analysis will not provide absolute answers to a specific issue. Instead, it enables the understanding of conditions behind the issue to highlight its essence and assumptions. By making the issue's assumptions explicit, the discourse analysis tries to enable us to gain a comprehensive view of the issue. Greater awareness enables us to solve concrete problems within the issue, not by providing unequivocal answers, but by making us ask fundamental questions.

The Powers (2001) method discourse analysis has three components: genealogy, structural analysis, and power analytic. The genealogy emphasizes the foundational discourses that provide legitimacy to the discourse under study. The structural analysis identifies forms of knowledge, authority, and values or justification related to the discourse. The power analytic uses text that describes resistance practices and the web of power relations in the discourse.

Genealogy

The genealogy identifies discourses that form the foundation for the discourse under study. The foundational discourses are bodies of knowledge that make the current discourse possible, contribute normative expectations within the discourse, and form the basis for how the discourse exercises its norms (power relations). For example, a discourse on training nurses would include influences from the foundational discourses of medicine, education, and professionalism.

Structural Analysis

A discourse's sphere of influence is identified by situating concepts, rules, and authorities in three axes. The axis of knowledge identifies discourse subjects, grids of specification, and discursive practices. The axis of authority identifies who has the right to speak in the discourse and systems of discourse preservation, exercise, and reproduction. The axis of value or justification identifies the "technologies of power" used in the discourse and the influence of foundational discourses identified in the genealogy.

Power Analytic

In Foucault's conceptual framework, "power is not a thing, an institution, an aptitude or an object (Foucault, 1978, p. 93)." Foucault's use of the word *power*, like his definitions of *genealogy* and *archeology*, is not the common-language use that refers to a concentrated ability to influence or resist others. Power is a productive network of relations within a discourse that works through people to create norms of what is right or wrong, acceptable or unacceptable; and of what can be considered truth (Foucault & Gordon, 1980). Power as a discourse relation is limited by the discourse boundaries. It is interwoven with other relations (e.g., family, work, peer) and has many forms; it is not limited to reward or punishment, is relatively coherent in support of the discourse values, and needs resistance. Ultimately, power resides in, and serves to promote, the core discourse values. The purpose of the power analytic is to identify the dominant web of power relations and resistance practices in a discourse.

Procedures

Discourse Sampling

The methodology of discourse analysis assumes that concepts, study participants, and the cultural system are bound in a social context (Phillips, 2001). Many forms of sociocultural representations are potential sources of text for analysis — for example, laws, social policies, informational and entertainment media, and people. The text in this study came from semistructured interviews and organizational policies. These two data sources provided sufficient text to enhance understanding of Navy leaders' patterns and meanings regarding mental health problems and mental health services.

Interview Sampling

This study used purposeful sampling for demographic homogeneity in order to focus on the subgroup of Navy leaders. Informational considerations, not statistical ones, determine the size of the sample in purposeful sampling. The goal is to maximize the informational content to the point of redundancy (Lincoln & Guba, 1985). The end-point for sampling to data redundancy occurs when the inductive data analysis process of unitizing and categorizing does not produce any new categories.

The interview sample frame included all Navy commanding officers, executive officers, and command master chief petty officers of surface fleet ships in southeastern Virginia that have between 200 and 1,300 assigned personnel. As Navy leaders, commanding officers, executive officers, and command master chief petty officers of naval units represent role-based positions that have formal organizational and cultural power over the careers and job assignments of subordinates. The interview sample was limited to surface fleet leaders because they supervise the largest population of sailors in the Navy and because their crews range, in occupational skills, from young sailors without technical training to highly skilled senior sailors. The direct influence of top leaders in an organization becomes more diffuse as the number of personnel increases and more personnel management decisions are made by midlevel managers (Gibson, Ivancevich, & Donnelly, 1988). Naval units with less than 1,300 personnel were used to increase the likelihood that the informants in this study were in a position to make direct decisions about subordinates' careers.

As of November 2003, there were 50 naval surface fleet units with 200 to 1,300 crewmembers assigned to a homeport in southeastern Virginia, with 40% of the fleet away from homeport (*Naval Vessel Register*, 2003; *Status of the Navy*, 2003). The Commanding Officer (CO), Executive Officer (XO), and Command Master Chief (CMC) in each of the 30 remaining fleet units provided a potential informant pool of 90 Navy leaders.

The University of Virginia Social and Behavioral Sciences (SBS) Institutional Review Board (IRB), Naval Bureau of Medicine and Surgery, Bureau of Naval Personnel (OPNAVINST 5300.8C, 2002) and Atlantic Fleet Forces Command review and authorizations were obtained before subjects were recruited. Participation in this study was voluntary. All participants received and signed an informed consent. Participant anonymity and personal privacy were guaranteed and safeguarded. No participant chose to withdraw from the study.

Recruitment of the study participants used the Dillman (2000) tailored design method of survey contact. Ninety recruitment electronic mail messages were sent, and 11 were returned as undeliverable. There were 25 responses to the 79 delivered recruitment invitations, for a 31.6% response rate to the first mailing. Interviews were completed for 19 or the 25 volunteers. Data redundancy of the interview text was noted after eight interviews. The 19 completed interviews was 2.4 times the minimum number of subjects needed for this analysis. The final interview sample included: 8 Commanding Officers, 7 Executive Officers, and 4 Command Master Chief Petty Officers. Total years of service ranged from 13 to 29, with an average of 20.21 years. The number of times they had experience in their current role ranged from 1 to 5 times, with a mode of 2 tours. All the participants had at least some college, and 14 had one or more master's degrees. The majority of participants were married (90%) and male (95%). The participants' self-reported racial groups were Caucasian (85%), African American (10%), and Hispanic (5%).

Policy Documents Sampling

The sampling strategy for the policy documents started with a keyword search of current, unclassified, public domain Department of Defense (DoD), Chief of Naval Operations (OPNAV), Bureau of Naval Personnel (BUPERS), and Bureau of Medicine and Surgery (BUMED) policies for the following terms: *mental health*, *psychiatric*, *psychiatry*, *psychology*, and *limited duty*. The goal of the keyword search was to identify all possible current Navy policies that would provide text related to naval mental health services and the structures of knowledge, authority, and value/justification. From a pool of 6,113 policy documents, 355 documents met the keyword criteria. Documents were excluded that did not inform or guide Navy leaders about mental health or illness issues for active duty sailors in the fleet. Most of the excluded policies were related to the assignment of mental health personnel, family programs, and medical practice. Each of the 31 policy documents retained for the study was saved as digital data to facilitate text-based analysis. Appendix B is the list of retained policy documents.

Interviews

Interviews of Navy leaders consisted of semistructured questions, responses to hypothetical vignettes, and demographic questions (Appendix C). The author conducted in person interviews that averaged 60 minutes. The semistructured questions focused on the respondent's leadership role and beliefs about mental illness without a specific context. This study used three vignettes to create common points of reference for the discourse. The three vignettes were developed by using the Link et al. (1999) method for constructing vignettes. The vignettes were developed to reflect sailors with a nonspecific personality disorder (Troubled Person vignette), adjustment disorder with depressed mood (Adjustment Difficulties vignette), and major depression (Depressive Symptoms vignette) (Appendix C). Each of the vignettes described symptoms of a mental disorder in a narrative format to engage the interviewee and concluded with the described person returning to active duty. Face validity of the vignettes was tested with Navy officers and mental health providers. Fleet Navy officers reviewed each vignette for typical case representation as one test of face validity. Frequently, the study participants commented on the accuracy of the vignettes and provided feedback on how to improve them for future use. Vignette content validity was based on review by mental health providers who read the vignettes for closeness of fit to Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR (DSM) (American Psychiatric Association, 2000) diagnostic criteria.

Data Management

A naturalistic qualitative study produces a significant amount of data. The data management for this study contained four steps. Obtained documents and interviews were transcribed into an electronic document as soon as possible after they were gathered. Collected text was systematically reviewed with the iterative analysis process for meaning units and categories as part of the data collection process. Fourth, interview and policy text was imported into HyperRESEARCH 2.6 (ResearchWare Inc., 2003) qualitative analysis software to facilitate coding, recoding, and content analysis.

Coding raw text data and categorical analysis form the two major steps in preparing interview text and policies text for discourse analysis. An inductive content analysis (Lincoln & Guba, 1985; Patton, 1987) was used to code text into meaning units. A code is a single piece of text that provides a description of meaningful content. Categories comprised codes that appeared to have similar characteristics. Each new interview was compared to the collective categories and meaning units of previous interviews. Evidence of data redundancy occurred when the labeling and indexing of a new data set did not create a new category or modify the rules of an existing category. No further revisions were made to the codebook after the eighth interview. The codes and categories comprised the minimum data elements for the discourse analysis. The iterative process of coding and categorizing was repeated with the retained policy documents. The unitized and categorized data points from the interviews and policy documents provided the data for the three components of the discourse analysis: genealogy, structural analysis, and power analytic.

Results and Discussion

Text passages from Navy policies and shipboard leader interviews were analyzed for their contribution to understanding mental health service use in the context of surface warfare ships. It was anticipated that stigma would be the dominant discourse in this study. As a discourse, stigma has the potential to create social relations and normative expectations in the context of mental health service use by subordinate sailors. Text representing stigmatizing beliefs appeared in this study. Stigma, however, did not hold a dominant position in forming organizational norms and expectations of leaders around mental health problems.

The dominant discourse identified in the text was fleet mental health (FMH). Fleet mental health as a discourse includes text related to mental illness, mental health problems, emotional development, emotional resilience, adaptive coping, psychiatric medicine, nonpsychiatric services, and mental health service use. Fleet mental health is selected as the discourse label in this study because of its central position in the discourse. *Fleet* refers to the social context of the Navy in the discourse. The term *mental health* is a broad conceptualization of psychological, emotional, and developmental phenomena. The term *mental health* does not belong to a profession; its presence or absence is defined by its social context; and it is used as a descriptive component for problems, services, and providers to note a relation to behavior and emotions. The discourse of FMH in this study is limited to the collected policy and interview texts. The analysis of the FMH discourse is conducted to identify normative expectations within the institution of the Navy surface fleet. The interview participants are referred to as "leaders" in the analysis text. The term *leader* is preferred to *participant* because of the role-bound expectations and responsibilities that dominate the discourse.

Genealogy

The genealogy identifies the foundational discourses that provide essential relationships for establishment of the discourse under study. Each of the foundational discourses has a social purpose, subjects, knowledge structures, and authority structures that can influence other discourses. Foundational discourses of Navy mission, surface warfare community, and Navy psychiatry are the dominant influences of the FMH discourse. Table 1. presents a component summary of the three foundational discourses.

Table 1. Summary of Foundational Discourses

	Navy Mission	**Surface Warfare Community**	**Navy Psychiatry**
Purpose	Maintain, train, and equip combat-ready naval forces capable of winning wars, deterring aggression, and maintaining freedom of the seas	Accomplish the Navy's seapower mission with maximum efficiency of personnel and materiel resources	Promote, protect, and restore the mental health of sailors, Marines, families, and retired veterans
Subjects	Active Duty Personnel, Civilian Personnel, Defense Contractors	Sailors, Leaders	Sailor-Patients, Mental Health Personnel
Knowledge Structures	Regulations, Directives, and Policies	Surface Warfare Qualifications, Ship Classifications, Job Classifications	DSM-IV-TR, Specialty Qualifications
Authority Structures	Uniform Code of Military Justice	Command Authority, Leadership Competencies	Professional Licensure, Clinical Privileges, Standards of Care

The foundational discourses of Navy mission, surface warfare community, and Navy psychiatry have their own individual spheres of influence, boundaries, and social norms (Figure 1). As expected, a high degree of commonality exists between the Navy mission and surface warfare community discourses. The Navy psychiatry discourse, however, has significant points of separation in each of the discourse components from those of the other two discourses. These differences create tensions between the discourses and the subjects within the discourses. The points of separation in the foundational discourses create a need for another type of discourse that can negotiate and integrate differences in a way that serves the Navy as a whole. The fleet mental health discourse provides that negotiating and integrating function.

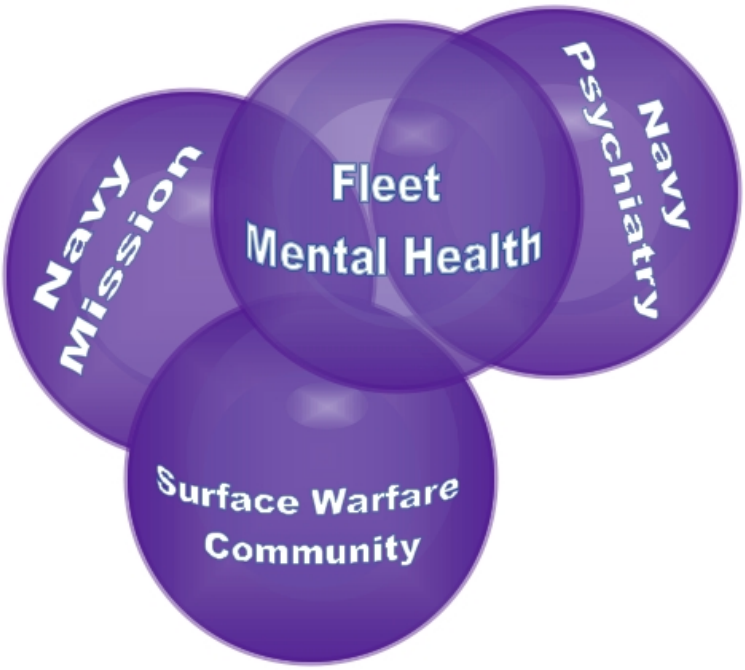

Figure 1. Graphic representation of the spheres of discursive unity

Structural Analysis

The genealogy provides an example of identifying discourse components from a position outside a discourse or without the knowledge that emerges from a discourse analysis. The structural analysis of the FMH discourse is written from a perspective within the discourse. The FMH discourse sphere of influence is identified by situating concepts, rules, and authorities in three axes. The axis of knowledge identifies subjects, grids of specification, and discursive practices. The axis of authority identifies speaking positions and rules. The axis of value or justification identifies the discourse's purpose and strategies for subject compliance. Table 2 is a summary of the FMH discourse components.

Table 2. Summary of Fleet Mental Health Discourse

	Fleet Mental Health Discourse
Purpose	To ensure that sailors are mentally capable of performing their shipboard duties while conserving those who are temporarily mentally unfit
Subjects	Sailor-Patients, Leaders, Mental Health Personnel
Knowledge Structures	Mental Health Policies, DSM-IV-TR
Authority Structures	Rules for discursive practices and speaking positions
Power Relations	Submission of sailors and leaders, Exploitation of foundational discourse authority structures

Axis of Knowledge

Subjects. The three subjects in the FMH discourse are sailor-patients, leaders, and mental health personnel. A subject formation that is unique in the FMH discourse compared with the foundational discourses is the sailor-patient. When a sailor engages in clinical services, he or she temporarily becomes a patient. The transition from sailor to patient and back again usually has clear boundaries (e.g., time and place of medical appointments) and is not problematic for minor acute illnesses. The transition of the sailor-patient role becomes problematic when a sailor returns to duty though still in need of treatment. For the remainder of the FMH discourse analysis, the term *sailor* will refer to the sailor-patient role.

Senior surface warfare leaders are career Navy officers and senior enlisted petty officers who have completed minimum education requirements and specialty leadership training. Surface warfare leaders have years of shipboard experience and have completed advanced certification of their knowledge of combat vessel systems and seamanship. The authority of surface warfare leaders is sanctioned by oath of office, naval regulations, and public recognition of military command.

In the Navy, mental health providers are clinicians with a specialty in psychiatry, psychology, clinical social work, or mental health nursing. The rules for professional practice are developed by professional organizations and sanctioned by state licensure. Mental health providers have the authority to declare the presence of mental disorders and to prescribe treatment.

Grids of Specification. A grid of specification is a systematic ordering of concepts relevant to a discourse that can be used to focus a particular body of knowledge on a subject or discursive practice. In the FMH discourse, there are seven grids of specification (Table 3). The dominant grids that drive the FMH discourse are the categories of mental health policies. It is important to recognize that no unified mental health policy exists within the Navy. Navy policies originate from widely diverse offices and resemble a collection of ad hoc prescriptions for responding to mental illness issues within specific, and separate, organizational contexts.

The two most influential categories are the suitability and disability policies and the security and reliability policies. Suitability and disability policies set the minimum requirements for sailors to enter the Navy and for disability determination for medical separation from the Navy. These policies reduce the likelihood that a sailor will have a mental disorder. Security and reliability policies set forth the requirements for sailors whose specialized jobs require access to classified information or nuclear material. These policies provide specific guidance for determining the initial and ongoing evaluation process to certify a sailor as loyal, reliable, and trustworthy. These two policy categories create an expectation of mental health capabilities that may not match actual mental health capabilities of individual sailors in the fleet.

Table 3. Fleet Mental Health Discourse Grids of Specification

Grid	Specification	Expected FMH Norm
Navy Mission Discourse Mental Health Policies		
Suitability and Disability	Requirements on who may enter and remain in the Navy	Sailors will be physically and mentally ready to perform their duties
Security and Reliability	Requirements for who may have access to classified information or nuclear material	Sailors who have access to classified documents or nuclear material are reliable and dependable
Mental Health Evaluations	Identifies events or behaviors associated with emotional distress and referral procedures	Sailors are to obtain appropriate mental health services with undue coercion or stigma
Support and Resources	Identifies mental health service functions related to administrative programs and occupational support	There are resources available for sailors and families to meet the demands of the Navy lifestyle
Surface Warfare Community Discourse Classifications		
Ship Classification	Mission expectations, living conditions, available resources	Larger ships have more resources to accommodate sailors with mental health problems
Job Classification	Minimum expectations for all surface ship jobs	The standard for acceptable mental health problems varies by job type
Navy Psychiatry Discourse Taxonomy		
Diagnostic and Statistical Manual	Diagnostic label, treatment expectations, and potential occupational functioning	Mental health problems will be appropriately labeled and a clear treatment plan or recommendation developed

Discursive Practices. Discursive practices are concepts that identify points in the discourse where the subjects exercise power/knowledge to influence others. Six dominant discursive practices were identified. The discursive practices as described by the leaders are fitness for sea duty, mission readiness, malingering, referral decisions, help-seeking, and career impact. It is important to note that one of the many challenges in reporting the findings of qualitative research is finding a way to represent the multidimensionality of text. The discursive practices are presented linearly on the basis of their relative influence in forming the FMH discourse; however, the actual text was not linear. The leaders' text was a complex juxtaposition of the discursive practices to highlight or modify a particular perspective. Within any given interview, the leaders would simultaneously connect attitudes about mental illness, their perspective on the sailor, the decisions they would need to make, and the impact of those decisions on themselves or their ship. It is important to recognize that no single discursive practice can stand independent of the influence of other practices or the FMH discourse itself.

Fitness for sea duty.

The severity of pretreatment symptoms and the circumstances surrounding the mental health referral were one yardstick the leaders used in determining fitness for returning to the ship. Pretreatment symptoms that were perceived as relatively minor and treatable were the most conducive to returning to sea duty. The leaders operationally defined mental illness consistent with the security and reliability grid of specification as primarily being a problem in coping with life stressors and social deviancy. Additionally, the leaders expected that, when a sailor was returned to the ship, underlying causes of the original problem had been addressed and the symptoms that precipitated treatment were resolved.

Leaders' personal experiences influenced decisions about how acceptable it would be to risk retaining a sailor with an identified mental health problem. The text of leaders who had experienced a crewmember's death due to mental illness was more cautious and reticent to accept a sailor after mental health treatment compared with that of leaders who had personal experience or family members with mental illness. Leaders who had observed or been impacted by a crewmember suicide while at sea had the strongest reluctance to accept sailors following treatment. Several leaders had personal experience or family members with mental health problems. It is important to note that some of the experiences in this group were traumatic and/or included significant disruption of family functioning. These leaders were more tolerant toward accepting sailors returning to sea duty after mental health treatment; they discussed continued monitoring as a helping behavior and saw medications as an effective adjunct to symptom management.

Given the leaders' concern for crew and ship safety, they expected that any potential for the sailor to cause harm to self or others was resolved. The leader ends up making a life-or-death decision with every sailor returned to duty if mental health problems are automatically associated with dangerousness. A large number of crewmembers need special certifications as a minimum job requirement. The fitness for sea duty text included the expectation that sailors need to be able to resume security clearance or nuclear personnel reliability certification.

The leaders' determination of fitness for sea duty was also influenced by their perception of the reliability of mental health evaluations. Lack of clear communication with mental health providers forces leaders to make their own assessments. Part of the lack of trust is related to differences in expectations between the surface warfare community discourse and the Navy psychiatry discourse. The leader expects a combat-ready sailor. For the mental health provider, sailors who are not imminently dangerous do not need a restrictive therapeutic environment and can return to the ship as fit for full duty even if further treatment is recommended. This difference in expectations results in the leader expending limited resources on what should be an unnecessary function — watching a healthy sailor.

The discursive practice of fitness for sea duty included concerns about the aftercare requirements of follow-up appointments and medication use. Support for follow-up appointments was dictated by the ship's schedule rather than by leaders' beliefs about mental health problems. In particular, the need for ongoing aftercare appointments was considered incompatible with a ship preparing for a long-term

deployment. In the text about shipboard medication use, the main concern was the crewmember actually following through and taking the medication.

The most common example provided of medication nonadherence was the sailor who needed antihypertensive medication. Consistently, the leaders indicated that they preferred that crewmembers relinquish control of their personal medications to the ship's hospital corpsman for dispensing. The primary justification was that the leader would then have a mechanism for monitoring medication compliance. The leaders also acknowledged that they were unsure of the rules for psychotropic medications on a ship. The leaders have good reason to be unsure about the rules: there is no policy guiding the use of psychotropic medication aboard Navy warships.

Mission readiness.

Use of mental health services impacts the leader's ability to fulfill the mission of the ship by consuming the leader's personnel management time and reducing available manpower. Time is a precious commodity in the surface warfare community discourse. Some leaders estimated that they spend 20% to 30% of their time related to crewmember mental health problems. Spending so much time on mental health issues meant the leaders were not spending time on other mission requirements. Many leaders were willing to support a sailor who needs ongoing therapy. There is, however, a cost for that support. A ship may have only one crewmember with a particular job skill. Sailors need to be able to do their job 100% when they return from any type of medical services. In response to manpower losses, the leaders must use their power and authority to increase the productivity of remaining crewmembers. Given the burden of manpower losses and demands on leaders' productivity, leaders have an incentive for keeping the number of sailors needing mental health treatment to a minimum.

Malingering.

The text on malingering was the most broadly elicited text in the interview. Even though leaders are powerful in the organization, they are also powerless when confronted with malingering in a context that includes the potential for self-harm. The stakes are very high for leaders. If they under react and the sailor commits suicide, there is needless loss of life, and they are held responsible. One of the perceived costs of sending a known malingerer for a mental health evaluation is the undermining of good order and discipline. Malingering is a violation of good order and discipline, a punishable offense, and a form of insubordination. The usual response to insubordination is for the leader to punish the behavior in a way that communicates to the entire crew that such behavior is not being tolerated and will not be tolerated. The leaders have the authority to punish malingering as insubordination; however, the authority to determine the presence of malingering belongs to Navy psychiatry. Malingering is perceived as inappropriately consuming limited command and medical resources. The leaders identified that sailors quickly learn how to use statements of self-harm as a way to shift power from the commanding officer to the sailor.

Referral decisions.

Available resources and Navy policy influence leaders' use of authority in making mental health evaluation referrals. Leaders are required to make a series of decisions when presented with sailors' behavior that may indicate a mental health problem. How the leaders choose to make those decisions depends on their level of knowledge and available resources. The leaders consistently used the disclaimer, "I'm not a clinician," to convey that they were not qualified to make clinical determinations about sailors' mental health. Specifically, the leaders identified the risks and frustrations as needing to determine the potential dangerousness of sailors with mental health problems. Even though commanding officers have absolute responsibility for sailors with mental health problems in their command, they need to use other resources to exercise that responsibility. Leaders on ships without physicians talked about their personal responsibility for making mental health referral decisions. Many leaders expressed role conflict about having to make clinical decisions while lacking the skill and knowledge to fulfill that responsibility. In contrast, leaders with physicians on their ships talked about sending the sailor with a potential mental health problem to the physician for referral decisions.

Leaders are required by policy to take certain referral actions in the presence of dangerousness to self or others, even if he or she doubts the sincerity of the presenting behavior. Mental health evaluation policies require the leader to simultaneously activate medical, legal, and administrative reporting mechanisms. Once initiated, the process cannot be stopped until the mental health evaluation is complete — even if the sailor gives reasonable assurances that the precipitating crisis is over. Another challenge in leaders' referral decisions is that mental health evaluation policies prohibit linking mental health referral to disciplinary action. Specifically, mental health evaluation cannot be used as a form of punishment, intimidation, or to discredit a sailor.

Leaders are forced to artificially separate behavior that is a threat to good order and discipline from reasons for mental health referrals. Uncertainty about the presence of a mental disorder makes it necessary for the leader to refer the sailor for mental health evaluation; doing so often forces him or her to delay or suspend punishment. A dilemma for leaders is that other crewmembers may misunderstand and begin to believe that mental health services can be used to avoid punishment or that leaders will tolerate the offending behavior.

Help-seeking.

Interview vignettes were used to explore leaders' perspectives about what encourages sailors to seek mental health treatment and what discourages them from doing so. The leaders indicated that leader and peer support and available resources are the strongest influence on help-seeking. Some leaders use their authority to effect the help-seeking behavior of sailors in two ways. First, sailors received a consistent message from the leader that values early help-seeking and the expectation that other leaders in the command will reinforce that message. Second, the leader advocates that crewmembers are encouraged, through the leadership, to be concerned about each other. Another consistent component of the help-seeking text was the influence of shipmates. Leaders' described peer influence as having both a deterrent and a supportive role. Peer stigma and

rejection was seen as a discouragement to help-seeking while peer acceptance was an encouragement.

The use of non-mental health services was also described in the context of help-seeking. The leaders' text identified the diversity of support services as a factor that encourages help-seeking. The presence of multiple non-mental health sources was used to identify that not all sailors with mental health problems [maladaptive coping] needed to go to mental health for services. The use of other services, however, can also be viewed as an avoidance behavior of Navy psychiatry. Some leaders advocated using their authority to screen sailors' problems and guide sailor's use of services. The mental health screening and treatment decision process is normally part of the psychiatry discourse.

Career impact.

The leaders in this study are in positions to impact the careers of sailors directly through performance evaluations and recommendations for promotion. Sailors with mental health problems create a challenge for the leader, who must make sure that evaluations include behaviors that impact work performance while ensuring that the evaluation is not biased. The leaders differentiated potential career effects on the basis of sailors' performance and positions of responsibility. Consistently, the leaders linked the concept of career impact with performance evaluation. Once linked to performance evaluations, the text focused on objective measures of mission support. Behaviors that impact work performance, including symptoms and loss of productivity during treatment, could be used in the evaluation. In the text on career impact and symptoms, the leaders included mental health treatment, with examples of sailors with migraine headaches, high blood pressure, and pregnancy, as having an impact on performance evaluations. Linking mental health treatment with other medical conditions de-emphasized the connection between mental illness and stigma and career impact.

The text on career impact included the relevance of rank and military position. The leaders indicated that mental health problems early in a Navy career have minimal career impact and that the demand for mental stability increases as responsibility increases. The officer and senior enlisted leaders had differing perceptions of career impact within their peer group. The officer participants, in particular, stressed that mental health treatment had a negative impact on careers of officers in their peer group. Many officers clearly stated that seeking mental health services will harm a senior officer's career. The implications from the interviews are that senior shipboard officers are held to a higher standard than others in powerful positions and that mental health problems are stigmatizing and have a negative career impact in certain contexts.

Axis of Authority

The authority of a discourse is different from the authority of the naval leaders. The naval leaders' authority is the power to act on behalf of the U. S. Navy. Their authority is set by congressional law and naval regulations. The axis of authority identifies the rules for the appearance of discursive practices, speaking positions, and proper concept forms within a discourse.

Appearance of Discursive Practices. There are three essential rules for the emergence of the discursive practices. They are the rules of problem recognition,

compromised productivity, and required leader action. For the rule of problem recognition, a sailor's behavior that suggests a mental health problem needs to be part of the leader's conscious awareness. In the compromised productivity rule, sailors' ability to work productively and to resolve their own problems needs to be perceived by leaders or mental health providers as compromised. This rule is important for subjects entering and exiting the discourse. In the third rule of required leader action, behaviors identified by the preceding rules require the leader to consider or engage mental health services. The requirement for leaders' decisions or actions activates the surface warfare community discourse. In that discourse, the leaders' absolute responsibility requires them to respond to any information that could affect the crew or ship. Fleet mental health discursive practices would not enter the discourse if sailors with mental health problems were participating in treatment outside the Navy without the leader's knowledge or if they did not require the leader to consider a mental health evaluation.

Speaking Positions. Speaking and writing positions in the FMH discourse refer to who can use the discursive practices with authority, speakers' credibility, ways of speaking, and acceptable sites for speaking within the discourse. There are three speaking positions in the broader FMH discourse: naval leaders, Navy institution through policies, and mental health providers. The leaders' role conveys both institutional and cultural authority to identify subjects and to use or respond to discursive practices. Leaders' attitudes about mental health problems are reflected in their speech and actions. Written elements of the discourse are reflected in the use of referrals for involuntary mental health evaluations, post-suicide attempt after action reports, and manpower documents for sailor attrition. As an institution, the Navy speaks within the FMH discourse through policies. The credibility and production of the policies are established by the use of experts as authors and an official signatory. The extent to which mental illness stigma may have influenced the authors of the policies is unknown. The policy text is written in two different styles. Mental health evaluation policies are written using DSM nomenclature and style. Security and reliability policies are written in lay behavioral terms. Mental health providers speak within the FMH discourse from their position as trained professionals with a specialized body of knowledge. Mental health providers speak and write within the conventions established by the DSM taxonomy. The provider is limited in the discourse by privacy expectations and case specifics.

Proper Concept Forms. The proper form that discursive practices must take to be accepted as knowledge and how imperfections in the discourse are resolved is the third rule type in the axis of authority. In the FMH discourse, proper formation of statements and subjects depends on context formality. The formal context is where all the subjects are role-bound in the discourse. For example, the sailor has an obligation to the ship and shipmates; the leader must respond to all potential threats; and providers must conduct an evaluation and provide a recommendation. In a formal context, the leaders must use discourse forms consistent with the policies that apply to the situation and providers must use the DSM taxonomy. The proper formal form of the discourse is behaviorally descriptive and linear; it is stated from the third-person perspective and stated with clearly identified role-bound authority. The informal context is created when subjects are not in role-bound situations. Examples of non-role-bound interactions include those

instances when leaders and providers are combined during varying forms of naval training, in social situations, and in the research interview where decisions and opinions were not binding. The informal discourse form was contextually descriptive (e.g., "We had only been out 6 days when…"), nonlinear, used lay or slang language (e.g., "not quite right," "crazy"), stated in the first person (e.g., "I had this one kid who…"), and stated as personal experience-bound authority (e.g., "This is what I think…").

Axis of Value or Justification

Within the FMH discourse's body of knowledge, discursive practices emerged from the interactions of subjects and foundational discourses. In this respect, the exercise of power in the FMH discourse is aimed at people. The social value of a discourse forms the justification for its use of disciplinary practices to subjugate the participants. The social value, the purpose, of the FMH discourse is to ensure that sailors are mentally capable of performing their shipboard duties while conserving those who are temporarily mentally unfit. The FMH discourse mediates the surface warfare community and Navy psychiatry discourses as sailors with mental health problems experience transitions in combat-readiness and move between the two discourses. Shared power/knowledge between the discourses is needed to ensure that sailors are productive and combat ready and to reduce unnecessary losses of trained sailors. Without mentally healthy, productive sailors who can obey orders and perform their duties, the social institution of the Navy cannot meet its mission of projecting seapower.

Power Analytic

The power analytic identifies the dominant power relations within the discourse. The FMH discourse power relations are modes of actions that support the discourse's purpose of mediating relationships between the foundational discourses. The power analytic was conducted in two stages. First, the dominant resistance practices of malingering, continued monitoring, avoidance of Navy psychiatry, and punishment were identified. Second, the resistance practices were then used as symptoms that expose the power relations.

Resistance Practices

Malingering. Malingering was a focal point of naval leaders' issues about mental problems, mental health services, and mission accomplishment. More than any other discursive practice, malingering evoked the strongest emotive response in the leader interviews. Malingering as a resistance practice has the following characteristics: The sailor as a malingerer is free to choose the use of mental illness symptoms to meet needs that are not being met in other discourses or to accelerate responses in the FMH discourse. For example, sailors who cannot get an authorized exemption from going to sea could use claims of suicidal thoughts to avoid departing with the ship. If sailors perceive that their psychological needs are not being met, or that they are not being afforded the attention they expect, they can choose to stimulate leaders and mental health providers through mental health claims that increase concerns about dangerousness.

Continued Monitoring. When a sailor is declared fit for full duty by psychiatry, the leader should not need to respond to the sailor any differently than he or she does to

sailors who did not have a mental health evaluation. When a sailor returns to duty after a mental health evaluation or treatment, however, monitoring by leaders continues. The resistance practice of continued monitoring was most likely to occur when the leader had difficulty trusting the provider's recommendation. Lack of trust was related to leaders' questions regarding the provider's fleet experience, professional skill level, and unsatisfactory communication between the leader and the provider before the sailor returned to the ship.

Avoidance of Navy Psychiatry. An FMH discourse norm is that sailors who require mental health evaluation or services need to be seen by providers whose practice is bound in the FMH discourse. Resistance to that norm occurs in two forms. The first type is for sailors to seek civilian mental health care with the expressed purpose of avoiding documentation in the military health record or provider communication with commanding officers. The second type is the use of administrative and occupational support programs as a surrogate for Navy mental health evaluation or treatment. This resistance practice can be used by sailors and leaders. Counseling and cognitive behavioral therapy provided by Fleet and Family Services and chaplains does not have the same organizational and stigma consequences as do psychiatric services. For example, a sailor with a security clearance does not face the same level of risk of losing his or her clearance by going to see a chaplain as would be the case if the sailor went to see a mental health care provider. Whether or not the use of administrative and occupational support is a resistance practice depends on the choices of the sailor or leader and compliance with discourse norms.

Punishment. Punishment as a resistance practice is most apparent among sailors labeled with personality disorders. Providers are excluded by suitability and disability policies from using medical limited duty and medical separation procedures for sailors with personality disorders. In response to those limitations, providers identify the sailor as fit for full duty and recommend an expeditious administrative separation. A medical recommendation for expeditious administrative separation is not sufficient for the leader to act on the recommendation. In addition to the psychiatry recommendation, the leader must document sustained impaired performance. One mechanism for documenting sustained impaired performance is through punishment. Punishment through the UCMJ can replace medical procedures for the separation of sailors diagnosed with personality disorders.

Web of Power Relations

Power relations in the FMH discourse are identified from the resistance practices. From the resistance practice of malingering, sailors are responding to the social norm that they are to submit their personal needs to the productivity of the ship. In the continued monitoring resistance practice, leaders are responding to the influence that they are to submit their judgment about sailors' suitability for sea duty to the authority of Navy psychiatry. From the avoidance of Navy psychiatry resistance practice, sailors are responding to the social norm that they are to submit to psychiatric evaluation and labeling of their thoughts and behaviors. The leaders in this resistance practice are responding to the social norm that they are to submit sailors to Navy psychiatry even

when that action may result in the sailor's loss or diminished productivity. In the resistance practice of punishment, the leaders are responding to the social norm that their absolute responsibility for sailors forces them to accept sailors with known mental health problems who are potentially unfit aboard the ship. The dominant power relations in the FMH discourse included the exploitation of Navy psychiatry and surface warfare community authority structures and the submission of the subjects.

The FMH discourse lacks the authority structures that enforce norms in the foundational discourses. To enforce its normative expectations, the FMH discourse exploits (takes advantage of) the authority structures in the Navy psychiatry and surface warfare community discourses. The Navy psychiatry discourse has authority to declare or deny the presence of a mental disorder, declare treatment options, suspend individual rights for treatment, and declare suitability for naval service. The surface warfare community discourse has the authority to compel sailors to participate in mental health evaluations, show up for scheduled appointments, and use performance evaluations or punishment as responses to sailors' behavior in the FMH discourse. The FMH discourse exploits the authority structures in these two foundational discourses to create power-over and domination influences over the sailors, leaders, and providers as discourse subjects. The power relation for sailors in the FMH discourse is submission to becoming a subject when they demonstrate or claim disruption of mental health. Once subjugated, sailors' fields of potential action are limited by the FMH discourse domains of mental health evaluation, treatment, and aftercare. Once in the mental health treatment domain, the sailor is subject to providers' labeling of mental disorders, determination for return to duty, involuntary admission, and recommendations of suitability for further service.

Summary

The Navy needs sailors who can do whatever is asked of them. Mental health problems create uncertainty about the mental capabilities of the sailors so affected. The Navy cannot afford to prematurely declare sailors with mental health problems as unfit because sailors are expensive to develop into combat-ready members. From the surface fleet perspective, sailors with mental disorders that render them permanently unfit should be removed from the fleet as quickly as possible. Sailors who are temporarily unfit, however, need some place in the organization to work on their problems until they are combat ready or identified as permanently unfit. A challenge for fleet leaders is that many sailors with mental health problems physically remain on the ships.

The purpose of the FMH discourse is to serve the Navy as an organization and to ensure that sailors are mentally combat ready while preventing premature loss of sailors who are temporarily not combat ready. To achieve its purpose, the FMH discourse exercises two types of power relations. First, the authority structures of the foundational discourses are used to promote the subjects' compliance with the procedures and expectations of the FMH discourse. Second, sailors and leaders must participate as subjects in a way that shifts some of their autonomy and authority to mental health providers.

Conclusions

A discourse analysis using Foucault's theoretical framework is a means to uncover systems of knowledge, power/knowledge practices, and power relations within a social context. Scientific literature regarding mental health services use and organizational culture suggested that mental illness stigma would be a dominant discourse in the context of Navy leaders' beliefs about sailors with mental health problems. The application of a Foucaultian discourse analysis in this study illuminated the presence of a discourse structure related to Navy mental health problems that was richer in context and more dominant than the anticipated discourse on mental illness stigma.

The most important finding of this study is the identification of the FMH discourse. The FMH discourse is a social power structure that emerged by default rather than design in response to surface fleet community and Navy psychiatry discourse incompatibilities. Lacking conscious design, the FMH discourse does not effectively meet the needs of the leaders who must use it to ensure that sailors are combat ready. In particular, the FMH discourse is limited by unclear or conflicted policies, inadequate communication between providers and leaders, slow response to dynamically changing fleet needs, and lack of leaders' knowledge. The FMH discourse limitations frustrate the leaders and undermine their authority. Over the past several years, the FMH discourse was increasingly being activated because of post-September 11th life stressors, increasing rates of job stress and depression in the military population (Bray et al., 2003), and wartime military service. The leaders subsequently experienced an increased demand for their attention and responsibility related to crewmember mental health problems during a time of increased productivity requirements for ship.

The second important finding is that stigma is not the major influence on leaders' attitudes about mental health services use. Leaders' text that revealed mental illness label based decisions were considered stigmatizing. The presence of stigmatizing interview text was consistently associated with the leaders' frustration in trying to manage a difficult problem without clear solutions. Dysfunctional elements in the FMH discourse may promote leaders' attitudes and behaviors that resemble stigma. Leaders' text illustrating decisions that were policy based or dependent on job performance was not considered stigmatizing. It was possible that the use of an overt determination of stigma in this study may underreport subtle stigma that is masked by compliance with policies that support stigmatized decisions.

The third important finding is that the mental illness malingering sailor personifies the worst of the FMH discourse. Malingering is a behavior that undermines leaders' authority and threatens crew cohesion. The FMH discourse policies and social norms prevent leaders from responding promptly and effectively. Leaders' frustration with malingering transfers to mental health providers who represent the ambiguity of the entire discourse.

The leaders in the present study responded to the questions and vignettes in the context of their day-to-day lives. By regulation and social expectation, Navy shipboard leaders have complex roles that require absolute responsibility. There are limitations on the scope and depth of knowledge that leaders can reasonably possess in meeting their responsibilities. In military parlance, the leaders need to rely on knowledge multipliers to

be able to meet their responsibilities and complete their mission. Opportunities to improve Navy mental health services exist as a knowledge multiplier for the leaders. The implications of this study are intended to strengthen the FMH discourse's ability to ensure that sailors are mentally capable of performing their duties and to improve processes used to respond to sailors who are temporarily unfit for duty. Opportunities to strengthen the FMH discourse include clarifying policy ambiguity, facilitating partnerships between fleet leaders and mental health providers, improved training, and increasing leaders' flexibility to promote sailors' mental health.

Policy ambiguity creates gaps in leaders' knowledge and organizational responsibilities regarding sailors with mental health problems. The gaps in knowledge and responsibility cause leaders' decisions and actions to be influenced by organizational legacy behaviors or personal experience. Policies with the most influential ambiguities are those related to security and personnel reliability programs, fitness for duty, and mental health evaluations of military personnel. The security and personnel reliability policies clearly show that the presence of a mental health problem or the associated behaviors are grounds for questioning a sailor's reliability. The policies, however, do not provide any guidelines to mental health providers to assist leaders in making the determination of reliability. Mental health criteria for determining reliability and specific administrative statements for use by providers to leaders need to be developed. The mental health fitness for duty policies related to shipboard sailors is long overdue for a systematic review. In particular, behavioral expectations that operationally define fitness for duty aboard a ship and the parameters for use of any medication that is not part of the ship's standard formulary need to be developed.

The cultural split between the surface warfare community and Navy psychiatry discourses creates disparities in access to mental health services and an opportunity for manipulation by malingerers. A major concern for leaders without a shipboard medical officer was continuity of evaluation, communication, treatment, and aftercare. The concept of fleet outreach, mental health liaison, or shipboard mental health visits is not new; it appeared to be effective and was well received by fleet officers in the mid-1980's (Glogower & Callaghan-Chaffee, 1984). Strategies for meeting the full range of mental health requirements on ships without a shipboard medical officer need to be developed and tested.

The leaders in the current study consistently identified a lack of knowledge necessary to make sound and consistent mental health-related judgments. Their current default position is to send the sailor for evaluation if there is any doubt whatsoever about mental competence. The advantage of early referral is to get sailors connected with services. The disadvantage is that many of the sailors referred will not meet clinical criteria for formal treatment. The low threshold for referral has further implications for increasing the Navy's manpower requirements for mental health providers. Mental health and mental illness are not separate from other activities in the Navy. Wherever existing Navy training content is focused on roles, relationships, or stress, there is an opportunity for integrating the principles of good mental health promotion. Leadership training is one area that could easily integrate mental health issues into the curriculum.

The Navy needs to move beyond responding to mental illness to promoting mental health. Shipboard leaders and the mental health system do not have the resources

to wait for the 20% to 25% of sailors who need mental health services to develop impaired functioning before they get help. Several leaders advocated for linking routine mental health screening to the Navy's physical readiness cycle to facilitate early problem recognition when more response options are available. Some leaders were well versed in the strengths and limitations of the various programs and knew how to match sailors' problems with available resources. Other leaders were not sure of what was available or the scope of provided services. A systematic review of available resources, program goals, and referral procedures needs to be completed for each homeport region.

Currently, explication of the FMH discourse is incomplete. This study focused on the leaders as the dominant authority figures in the sailor-leader-provider triad. The text of sailors and providers is absent. The next study needs to analyze text from sailors and providers. Minor modifications in the vignettes are needed so that they reflect recent changes in security and operational expectations before this study is replicated with sailors and providers.

This study contributes to the current literature on mental illness beliefs among military leaders. Specifically, this study assessed power relations and discursive practices related to mental health problems and treatment in the context of a hierarchical work setting. Understanding attitudes toward mental health problems among those who hold power over individuals is important to the study of stigma, health beliefs, and mental health service use. The current study also provided data on attitudes toward mental health problems in a healthy workforce rather than the symptoms of persistent severe mental illnesses that is more frequently identified in stigma related research.

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Appendix A
Glossary

Glossary

Axis of Authority — A form of rule about what can be said and who can speak within the discourse. The discursive rules determine how discursive practices appear, who is allowed to speak, and the proper form of discourse concepts.

Axis of Knowledge — Identifies the discourse core elements of subjects, grids of specification, and discursive practices.

Axis of Value or Justification — Identifies how the discourse justifies the use of power on people and other discourses.

Disciplinary Techniques or Practices — Social mechanisms, such as controlling rewards and punishment, that are used to encourage subjects to abide by the discursive rules and act in a way that supports the discourse. The concept of tools and practices includes the use of social constructs, such as laws, regulations, social class, and professionalism, that leverage human behavior.

Discourse — A system of knowledge that influences language, perceptions, values, and social practices. Discourses function to fulfill a social purpose and to maintain social order through an authoritative way of creating normative expectations.

Discourse Analysis — A critical analysis of the use of language and the reproduction of dominant ideologies (belief systems) by exploring ways that theories of reality and power relations interact as social practices.

Discursive Practices — Points in a discourse where the subjects exercise power/knowledge to influence others. Dominant discursive practices are identified by examining meaningful speech acts that engage multiple foundational discourses and grids of specification.

Genealogy — Identification of the foundational discourses that make the current discourse possible, contribute normative expectations within the discourse, and form the basis for discourse norms.

Grid of Specification — A systematic ordering of concepts relevant to a discourse that can be used to focus a particular body of knowledge on a subject or discursive practice. For example, a list of symptoms would be a grid of specification for identifying a disease.

Power — A productive network of relations within a discourse that works through people to create norms for what is right or wrong, acceptable or unacceptable, and what can be considered truth.

Power Analytic — Identification of the dominant web of power relations and resistance practices in a discourse.

Power Relation — "A mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on possible or actual future or present actions"(Foucault, Rabinow, & Rose, 2003, p. 137). A power relation has two defining elements. First, the person whom the power is exercised is free to act and maintains his or her agency within the discourse. Second, the exercise of power is not on the person but on potential actions.

Power/Knowledge — An active process that gives words meaning, influences perceptions, facilitates comprehension, and guides interaction. Conceptually, the combined influence of power and knowledge in a social system is to describe normative expectations and regulate what it describes.

Resistance Practices — An act of autonomy within a structured set of institutions and practices. Resistance is a form of creativity of a free person within the discourse that serves the needs of the individual versus the norms of the discourse.

Structural Analysis — Identification of the knowledge, authority, and value/justification axes of a discourse.

Subjects — Individuals who are participants in the discourse. The agency of a subject lies in the constant interplay between strategies of power and resistance, not in the self-consciousness of the subject.

Surfaces of Emergence — Points in a discourse where the foundational discourses and the discourse under study share concepts.

Technology of Power — Disciplinary tools or practices which influence the conduct of individuals and submit them to the norms of the discourse.

Truth — The dominant set of discursive practices within a discourse.

Appendix B
Retained Policy Documents

Retained Policy Documents

Subject	Policy
Suitability and Disability	
Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces	DODINST 6130.4
Psychological Screening of Recruits	OPNAVINST 1100.6
Suitability Screening for Overseas and Remote Duty Assignment	OPNAVINST 1300.14C
Enlisted Administrative Separations	SECNAVINST 1910.4B
Administrative Separations of Officers	SECNAVINST 1920.6B
Physical Disability Evaluation	DODINST 1332.38
Disability Evaluation Manual	SECNAVINST 1850.4E
Mental Health Evaluation	
Mental Health Evaluations of Members of the Armed Forces	DODINST 6490.1
Requirements for Mental Health Evaluations of Members of the Armed Forces	DODINST 6490.4
Requirements for Mental Health Evaluations of Members of the Armed Forces	SECNAVINST 6320.24A
Victim and Witness Assistance	OPNAVINST 5800.7
Sexual Assault Victim Intervention (SAVI) Program	OPNAVINST 1752.1
Management of Alleged or Suspected Sexual Assault and Rape Cases	NAVMEDCOMINST 6310.3
Conscientious Objectors	DODDIR 1300.6

Subject	Policy
Security and Reliability	
Personnel Security Program and Civilian Personnel Suitability Investigation Program	DODAI 23
DoD Personnel Security Program	DODINST 5200.2R
Overseas Security Assistance Organizations	SECNAVINST 4900.49
Personnel Security Program	SECNAVINST 5510.30A
Nuclear Weapon Personnel Reliability Program	DODINST 5210.42R
Nuclear Weapon Personnel Reliability Program (PRP)	SECNAVINST 5510.35A
Changing or Removing Primary Navy Enlisted Classification Codes for Nuclear Propulsion Plant Operators	OPNAVINST 1220.1B
Support and Resources	
Navy Occupational Safety and Health Program Manual for Forces Afloat	OPNAVINST 5100.19D
Combat Stress Control	DODDIR 6490.5
Secretary of the Navy Crisis Response Preparedness Program	SECNAVINST 3006.1
Family Advocacy Program	DODINST 6400.1M
Family Advocacy Program	OPNAVINST 1752.2A
Family Service Center Program	OPNAVINST 1754.1A
Department of the Navy Corrections Manual	SECNAVINST 1640.9B
DoD Health Information Privacy Regulation	DODINST 6025.18R
Air Transportation Eligibility	OPNAVINST 4630.25C
Support of U.S. Antarctic Program	SECNAVINST 3160.2B

Appendix C
Interview Guide

Interview Guide

Note: Words in italics are not read nor presented to the participant.

Section 1. Open Interview

Before we begin, I wish to thank you for agreeing to participate in this study. I am going to ask you several questions with regard to mental health, mental illness, and a sailor's use of mental health services. The interview will have three sections. The first section is a series of general questions regarding mental health issues in the Navy. The second section consists of three vignettes with a common core of questions following each vignette. The third section is very short and consists of the demographic questions. To begin:

1. Tell me your ideas of what mental health and mental illness are.
2. What do you think are the causes of mental illness?
3. How would you know if a sailor's behavior is malingering or mental illness?
4. If you thought that a sailor was having mental problems, what would you do?
5. What are your expectations about what will happen when a sailor gets mental health treatment?
6. To what extent do you think someone sent for mental health treatment should return to active duty?
7. What do you think about someone who has received mental health treatment coming back under your command?
8. As best as you can tell, what encourages or discourages sailors in your command from seeking mental health care, before they get really sick?
9. As a leader, what are some of the barriers you face when you have a subordinate who needs mental health evaluation?
10. In your opinion, can seeking mental health care harm a sailor's naval career? How?
11. What changes would you recommended to improve Navy mental health services?

Section 2. Vignettes.

Often, it is helpful to use case studies or vignettes when discussing complex issues or situations that do not have clear right or wrong answers. Next, I have three short vignettes that are examples of the most common mental health issues in the Navy. We will use the vignettes to help clarify some of the issues surrounding mental health services. The vignettes describe a Petty Officer whose rating does not require a security clearance or PRP monitoring. I will read the vignette and then ask you several questions to guide our discussion.

Hand participant card with the vignette.

Vignette 1 (Troubled Person)

Petty Officer Smith is a career oriented sailor who reported on board about six months ago. Initially, Petty Officer Smith appeared to be a hard-charger who was effective in completing routine and contingent tasks. Other than poor people skills, Smith seemed to be a good sailor. At first, Smith's short tempered and abrupt manner was attributed to motivation to get the job done. Smith's Senior Chief attempted several times to guide the Petty Officer's management skills by praising the success of the task and suggesting other ways Smith could have lead subordinates to the same results. The Senior Chief was getting frustrated because Smith consistently misinterpreted the guidance as either a personal attack or criticism that the job wasn't done right.

Recently, Petty Officer Smith became more unpredictable. Smith would yell at subordinates for minor mistakes and was frequently involved in arguments with peers. Off duty, Petty Officer Smith seemed impulsive. Smith had several traffic tickets for speeding, had been seen at an off-limits night-club, and purchased a sports car at a high interest rate. Following an outburst where Petty Officer Smith was angrily disrespectful toward his division officer, Smith confided a long history of trouble getting along with others and controlling anger. Petty Officer Smith voluntarily agreed to a mental health evaluation and returned to duty with a referral for a two-week stress management course.

Vignette Questions

1. In your opinion, what might be some of the causes of Petty Officer Smith's symptoms or behaviors?
2. Were Smith's symptoms worrisome enough to warrant mental health evaluation?
3. To what extent do you believe that treatment will be effective for Smith?
4. What do you think would happen if Petty Officer Smith did not participate in treatment?
5. What concerns would you have about Petty Officer Smith's return to the command?
6. What considerations would you give to Petty Officer Smith upon returning to duty?
7. What impact could treatment of a mental health problem have on the Smith's career?
8. Is there anything else that you wish to discuss in regards to this vignette?

Hand participant card with the vignette.

Vignette 2 (Adjustment Difficulties)

Petty Officer Jackson is a sailor who was assaulted by a fellow crew-member while off-duty. The attacker was found guilty by a court-martial. With a history of positive work performance and support from character witnesses, the attacker was sentenced to a reduction in rank, a fine, and 30 days restriction to the ship. Petty Officer Jackson was angry about the punishment because it meant that Jackson would still see the attacker every day on the ship and the attacker was still senior to Jackson in rank.

Two months after the court martial, Petty Officer Jackson's work performance began to deteriorate. For example, Jackson would forget details, partially complete tasks, and not adequately supervise the work of subordinates. Petty Officer Jackson appeared sad,

sometimes tearful, and stopped working towards advancement. Conversations with Petty Officer Jackson would often focus on how the command and the Navy legal system were inadequate and a sense of being trapped on the ship. Additionally, the use of Sick-Call for a wide variety of complaints and illnesses increased from before the assault. During a performance counseling session, Petty Officer Jackson stated, "I can't deal with this anymore" and asked to go to medical. After talking with the Corpsman, Jackson volunteered for a mental health evaluation. Petty Officer Jackson was admitted to inpatient psychiatry for four days and then participated in a two-week intensive outpatient treatment program. Petty Officer Jackson has been cleared by psychiatry and has returned to full duty.

Vignette Questions

1. In your opinion, what might be some of the causes of Petty Officer Jackson's symptoms or behaviors?
2. Were Jackson's symptoms worrisome enough to warrant mental health evaluation?
3. To what extent do you believe that treatment will be effective for Jackson?
4. What do you think would happen if Petty Officer Jackson did not participate in treatment?
5. What concerns would you have about Petty Officer Jackson's return to the command?
6. What considerations would you give to Petty Officer Jackson upon returning to duty?
7. What impact could treatment of a mental health problem have on Jackson's career?
8. Is there anything else that you wish to discuss in regards to this vignette?

Hand participant card with the vignette.

Vignette 3 (Depression Symptoms)

Petty Officer Ray started having marital and financial problems at home about two years ago. Marital counseling with the chaplain helped some, but the relationship remained strained. Working with a command financial advisor, Petty Officer Ray developed a financial recovery plan that would reduce the debt but left little money for non-essential spending. About eight months ago, Petty Officer Ray had several weeks of feeling really down. Ray was not sleeping well and would wake up in the morning with a flat heavy feeling that stuck all day long. During this time, it was difficult for Ray to have fun or experience pleasure. Petty Officer Ray was an avid runner but no longer found enjoyment in running or any exercise. Even when good things happened, like a top-five time for the PRT run, they didn't seem to make Ray happy. Petty Officer Ray would push on through the days and found that the smallest tasks were difficult to accomplish. Concentrating on any task was hard and Ray's work suffered due to lack of attention to detail. Even though Ray felt tired, the nights were spent lying awake filled with worry. Feelings of worthlessness and failure were a common theme in Ray's thinking.

Over the course of two months, family, friends, peers, supervisors, and the ship's corpsmen began expressing concern for Petty Officer Ray's well being to Ray and each other. Following a visit to medical for fatigue, the corpsmen referred Ray to mental health. The treatment that Petty Officer Ray required conflicted with the ship's schedule

and necessitated orders off the ship. Ray participated in six months of limited duty for treatment that included medication, individual therapy, and group therapy. Petty Officer Ray responded well to treatment. According to the treating psychiatrist and the medical evaluation board, Petty Officer Ray is fit for full duty while continuing to take Prozac to prevent relapse and is reporting to full duty on your ship.

Vignette Questions

1. In your opinion, what might be some of the causes of Petty Officer Ray's symptoms or behaviors?
2. Were Ray's symptoms worrisome enough to warrant mental health evaluation?
3. To what extent do you believe that treatment will be effective for Ray?
4. What do you think would happen if Petty Officer Ray did not participate in treatment?
5. What concerns would you have about Petty Officer Ray's reporting to the command?
6. What considerations would you give to Petty Officer Ray upon returning to duty?
7. What impact could treatment of a mental health problem have on Ray's career?
8. Is there anything else that you wish to discuss in regard to this vignette?

Section 3. Demographics and Personal History

Thank you for your thoughtful answers to the questions and discussion of the vignettes. I have few final questions that will help me to understand your answers in the context of your career and life experiences.

1. How many total years of military service do you have?
2. How many times have you been a (CO, XO, CMC)?
3. For some people, prior experience with mental health services influences how they see those services. Has a social acquaintance ever used mental health services? In what ways did that experience influence the discussion that we have had today?
4. What is your highest level of education?
5. Are you currently married?
6. What racial group do you declare on standard Navy survey's?
7. *Gender M F*
8. Would you like to review and comment on the ideas and themes of the study before I write the final results. This review would take an additional 15-30 minutes. *Yes No*
9. Is there anything else regarding mental health services you wish to share with me?

That concludes the questions that I have for you during this interview. Thank you for sharing with me today your valuable experiences and insights.